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VOLUME 22 NUMBER 4

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Presenting...

Linacre's Winter Issue

Mr. T. Raber Taylor, author of our medico-legal article this quarter is a practicing attorney in Denver and has been the lecturer on problems in this field at the University of Colorado School of Medicine since 1939. The establishment of a medical examiner's system in the city and county of Denver was advocated in one of his articles appearing in the *Rocky Mountain Medical Journal* entitled "Scientific Findings on Death and Coroner's Inquest." Productive action was taken in the States of Colorado, New Mexico, Utah and Wyoming, resulting from the framework of these findings. Admitted to practice before the bar of the Supreme Court of the State of Colorado and the Supreme Court of the United States, and the United States Circuit Court of Appeals for the Tenth Circuit as well, Mr. Taylor is a member of many federal administrative agencies, including the United States Tax Court.

Well remembered for the valuable article contributed to an earlier issue of LINACRE QUARTERLY "Is Therapeutic Abortion Scientifically Justified?", Dr. Roy J. Heffernan this time reaches our readers with his thoughts on the obligation of medical men to teach, not as an act of charity but a duty if progress in the field of obstetrics is to continue.

A graduate of Tufts Medical School in 1917, Dr. Heffernan served in the U.S. Naval Medical Corps during the first World War. Among other honors, he is a Fellow of the American College of Surgeons; Fellow of the American Academy of Obstetrics and Gynecology, Diplomate of the American Board of Obstetrics and Gynecology, Fellow of both the Boston Obstetrical Society and the New England Obstetrical and Gynecological Society, serving as president of both. Dr. Heffernan is surgeon-in-chief, department of obstetrics and gynecology at Carney hospital, Boston; asst. clinical professor of obstetrics and gynecology, Tufts Medical School, and a member of the Boston Catholic Physicians' Guild.

Another former contributor to LINACRE QUARTERLY is Dr. Charles Leavitt Sullivan who, with Dr. Elmore M. Campbell, give us the article "One Thousand Cesarian Sections in the Modern Era of Obstetrics." Dr. Sullivan is a member of the American College of Surgeons and also a Diplomate of the American Board of Obstetrics and Gynecology. Dr. Campbell is a Fellow of the American Academy of Obstetrics and Gynecology and a member of the New England Obstetrical Society. Most of his work is done at St. Elizabeth's and St. Margaret's hospitals in Boston. He served as Captain in the U. S. Army for two and a half years. Both are members of the Boston Catholic Physicians' Guild.

Father Gerald Kelly, S.J. continues with his important series, "Doctors Ask These Questions," covering four more topics of interest to our readers.

Father John J. Lynch, S.J. is back with us again for the November issue discussing the doctor's obligation to tell the cancer patient of his condition. His thoughtful comments should be of great help to the physician faced with making the best decision in this matter. "What Must the Cancer Patient Be Told?" will resolve doubts that may have been confronting many.

The Physician, The Hospital and Our Obligation to Teach

ROY J. HEFFERNAN, M.D., F.A.C.S.

SIR WILLIAM OSLER was once reproved by an older practitioner for his loquacity with a patient and her family during a consultation. "Young fellow," said the gruff old doctor, "you talk too much — I've practiced medicine forty years with a nod of the head."

Osler was a young man then, and it is fortunate indeed for the healing art that this rebuke proved no deterrent later to his facile tongue or pen.

The fine work done in Catholic medicine today should not be dismissed "with a nod of the head." It would seem advisable that we Guild members should be a little less reticent concerning the remarkable progress made in recent years in our hospitals, particularly in maternal welfare.

The last twenty-five years have brought to fruition more major advances in obstetrics than any one century in the past. Since 1951 the maternal mortality has been under 1 per 1000 live births. Infection has been controlled and the horror of hemorrhage has been almost eliminated. Anesthesia is a respected science of the specialist, eclamptia is almost unknown, and the public is no longer amazed that a three-pound baby survives.

All of these changes had one basic common denominator — the hospital. Maternal mortality has dropped almost in direct proportion to the rise in hospital births. The hospital, at first a place where antisepsis was organized, became the clinical laboratory where aseptic technique grew up and where willing attendants eventually became expert assistants. The hospital labor room became the seat of learning and the delivery room the font of skill in the art of obstetrics. The hospital gradually acquired such stature that the term "hospital facilities" has become synonymous with anesthesia, blood banks and operating room teams on a twenty-four hour schedule staffed by expertly trained personnel. So much publicity has been given to this progress in current newspapers and popular journals it would almost indicate that every perfection has been attained in obstetrics; that all problems have been solved, and that we must seek new worlds to conquer.

With the reduction in maternal mortality to its present low level there has been naturally a tremendous drop in deaths from hemorrhage, toxemia, and infection. Better maternal care has necessarily influenced neonatal death and stillbirth rates for the better. However, notwithstanding this enviable record of progress, much remains to

be done. If we look to the statistics among the Negro race, for example, we find that the maternal mortality is two and one-half times that of the white; that there is a 60% greater neonatal death rate, and that the still-birth rate is 85% greater than that among white mothers. In the last year, for which complete statistics are available, slightly more than five thousand women died in the United States giving birth to live children. In this day of modern obstetrics, possibly the most tragic feature of these deaths is the fact that 50% of them could have been prevented. Within that year there were seventy-five thousand still-births; 68% of them were between the thirty-sixth and fortieth week of pregnancy, and in 71% of these cases there was a history of hypertension and albuminuria in the mothers, indicating that prenatal care could have saved the vast majority of these. There were seventy-nine thousand neonatal deaths, of which sixty-nine thousand were considered preventable. The total infant loss represented 10% of all the deaths in the country. As striking as these figures are, even more startling are the reasons why so many of these were considered preventable.

Number one was the lack of prenatal care. The reasons for this grave neglect were to be found in faulty education of the public in certain areas, lack of cooperation on the part of the patients, poor training among some physicians, and in some instances an improper spirit of community responsibility.

Number two was poor hospital facilities. By this was meant, in some instances, hospitals which had been converted from other structures and which were thereby inadequate. But in addition, it also refers to hospitals of modern construction but whose facilities were significantly absent or deficient.

Number three was lack of blood. This meant that there was not enough blood given to some patients; that there was not enough blood available for others. It meant also that there were certain hospitals which, in this day and age, are still lacking a blood bank.

Number four was poor hospital care. This was defined as meaning poor nursing care, personnel inadequate in training or in numbers, or an insufficient number of doctors and nurses qualified in basic obstetrics so that they might recognize complications early and call for assistance at a propitious moment. It is obvious, therefore, that a hospital today has grave responsibilities. If these statistics are to be improved at all, it is essential that every hospital, without exception, do its share.

First there must be cooperation in a program of public education. The intelligent use of trained social workers, and a program of medical training, with at least provision for clinical research, must also be considered. These latter two must be singled out for particular comment. There has been a tendency in recent years to maintain that the Catholic hospital cannot compete on a teaching or research basis with non-Catholic institutions. If the major causes of maternal mortality and fetal loss are represented

in the lack of prenatal care and deficiency in training of both nurses and doctors, then no hospital, particularly in the larger areas, will be able to justify its existence if it does not contribute in a major way to the training of the physicians and nurses of tomorrow. The obstetrical unit or hospital holds a special place in Catholic medicine. Medical-moral thinking begins there. It represents the first-line trench in the scientific defense of fundamental morality, the family and society itself. If we are to be spared the end-results which logic and experience tell us will follow therapeutic abortion, birth control, and sterilization, then the scientific evidence proving that such practices are as unnecessary as they are vicious must be forthcoming. Even the most casual student of obstetrics will find that the chief causes of maternal and fetal loss are represented as the chief "reasons" for birth control, sterilization and therapeutic abortion. Progress in the former instance must necessarily disprove the validity of the latter. Truly, it would seem that the circumstances of modern obstetrics represent a providential challenge to Catholic medicine.

The answer to such a challenge lies in research and a teaching program. Research seems to be a frightening term, apparently connoting to many an alchemist's dungeon, presided over by a group of introverts who periodically submit a budget that could only be successfully underwritten by the U. S. Mint. Actually, clinical research is relatively inexpensive, is productive of practical information, and is underwritten in large measure by pharmaceutical houses, private foundations, and various governmental agencies. It is furthermore the means by which the experience of the older doctors or nurses can be utilized, where the keen, younger members of our profession can prove their ability to investigate and write, and by means of which hospitals may attract the attention of those institutions whose purpose is to foster and support the more expensive laboratory research. It is only in such a way that the story of the millions of deliveries accomplished each year in Catholic hospitals with excellent records and without recourse to therapeutic abortion or sterilization can be told.

To be able to tell such a story and to be able to tell a better one each year, there must be a teaching program. The story must be taught and there is an obligation to teach it. If the obstetrical authorities of tomorrow are to maintain that you don't have to kill a baby in order to heal its mother, it must be proved to them today. If the mother with heart trouble is to enjoy a family, then all physicians must have it proved to them now. Every Catholic obstetrician and nurse who is trained under non-Catholic or anti-Catholic auspices offers proof that our word is not being followed by the deed.

The "cottage" hospital of yesterday, in a new, enlarged edition, is masquerading today in too many instances under the name of the "community" hospital. The community hospital has its place, and God bless it, as it does render high

service and frequently under great hazards. But the community hospital in a metropolitan center is sterile. It is an "obstetrical hotel" that bears no future fruit. The hospital which has five men on its staff, each with twenty years in obstetrics, and does no teaching is wasting a century of valuable obstetrical experience.

The modern obstetrical unit is a living thing; it is a well-organized team—set up, ready and proud to challenge the unexpected, the fulminating, and impending disaster with uncompromising faith, and with a scientific knowledge as complete and as detailed as God has given us the power to discover.

In the light of modern facts about obstetrical problems our obligation to make progress and to teach is no longer simply one of charity. Our obligation in this regard towards the mothers and babies of today is one in justice as well.

In the days of the pagan, Hippocrates, it was considered the bounden obligation of members of the healing art to teach. As followers of One who has been reverently called The Divine Physician, the medical and nursing staffs of our Catholic obstetrical hospitals should be honored to emulate the example of those who obeyed the advice to "go and teach all nations."

[EDITOR'S NOTE: *Dr. Heffernan first considered some of the material presented here when an article he wrote for* THE CATHOLIC NURSE *appeared in the December, 1954 issue of that publication. We asked him to enlarge his thoughts on the subject to emphasize the obligation of the physician and the hospital to advance teaching programs and to develop research.*]

FEDERATION EXECUTIVE BOARD MEETING SCHEDULED

The Executive Board of the Federation of Catholic Physicians' Guilds will meet Dec. 3-4, 1955, beginning at 9:30 a.m. at Hotel Statler, Boston, Mass.

The Officers of the Federation and one delegate from each active constituent Guild constituting the Board will conduct business.

One Thousand Cesarean Sections in the Modern Era of Obstetrics

CHARLES LEAVITT SULLIVAN, M.D., and ELMORE M. CAMPBELL, M.D.

FACTORS RESULTING in the amazing reduction in maternal mortality in the era of modern obstetrics are reflected in the increased incidence and safety of cesarean section. In the general population of the United States the maternal mortality in 1953 was less than 6 per 10,000 live births. In other words, there was only 1 maternal death for every 1800 births, whereas only 5 years earlier the ratio was 1 in about 950 births, and 10 years ago 1 in about 450.[6] During this period the use of cesarean section has increased at least two-fold and has replaced the brutalizations of craniotomy, accouchement forcé, and the lethal meanderings of scientific apprehension. There is, of course, a point of diminishing returns in this surgical application in preference to vaginal delivery and it remains for the future to set the cesarean section rate at the proper level. That we have not reached this apogee is evidenced by the marked disparity in section rates throughout the country, varying as they do from 0.5 to 14%.[1]

Lahey and Ruzika have pointed out, with data from a large number of cases in five teaching hospitals on three continents, that the expected mortality during any operation and anesthesia from all causes is 1:1000.[4]

From St. Elizabeth's Hospital, Boston, Mass.; C. L. S., visiting obstetrician; E. M. C., assistant visiting obstetrician.

Presented at the 1953 Annual Meeting of the Massachusetts Medical Society.

We are indebted to Sr. Elizabeth Marie, O.S.F., for her cooperation in this study.

Potentialities of Cesarean Section

Pregnancy is an equal partnership of mother and baby, which is dissolved only by the discharge of both in good health. Neither an abdominal scar, an unwarranted fear of the future, the derogation of fetal life, nor the indecent pride in statistics are considered important enough to alter this philosophy. In the mind of the laity, as well as in that of the physician, there exists a deep misunderstanding of the potentiality of cesarean section. The fact that a pregnant woman is as subject to the uncertainties of this mortal existence as is her barren sister is readily forgotten in the light of the ever-decreasing maternal mortality rate. Nothing in this procedure will mitigate a pathologic lesion which would have been fatal whether or not the woman was pregnant.

For years there has been fostered the concept of cesarean section, in many cases, as nothing more than a deliberate attempt to salvage the life of the child at the direct expense of the mother's. De-Normandie, reporting on 11,117

sections with a mortality rate of 2.4%, as late as 1942, did nothing to dispel this misinterpretation; in his series fully two-thirds of the infants born of mothers who died of their complications or operations survived, and were carried home to motherless childhoods.[2] The physician deludes himself in thinking that abdominal delivery will repair the ravages of prenatal anoxia or in some fashion mend the torn cerebral vessels caused by traumatic labor carried too long, or that it will add weeks of development or ounces of weight to the immature or premature infant. There are some, forgetting that infection from the lower uterine segment and cervix may be spread by the lymph and blood systems as well as by contiguity, who expect the type of section performed to eliminate entirely the possibility of peritoneal infection.

Two Approaches to Obstetric Problems

In this search for proper balance there is both an academic and a practical approach to the problems of obstetric pathology. Table 1 indicates the results in a series of

TABLE 1. 1887 REPORTED CESAREAN SECTIONS, 1934-1943

	Private (%)	*Ward* (%)	*Difference*
Incidence	6.7	3.2	½ frequency
Morbidity	16.5	24.5	50% higher
Maternal mortality	1.1	1.4	3 maternal deaths/1000 higher
Fetal mortality	5.5	7.8	40% higher

1887 cesarean sections, delineating the difference between the two.[3] With half the number of cesarean sections on the ward side, in those cases where the operation was eventually performed, the fetal mortality associated with it was 40% higher than in private cases, the maternal morbidity was 50% greater, and maternal mortality increased by 3 maternal deaths per thousand. It is clear that to press too hard in an effort to keep the incidence of abdominal delivery at a low level will place an unwarranted burden on those whose condition eventually will require delivery by cesarean section.

Material and Method

The material presented represents a series of 1000 consecutive cesarean sections performed by the staff of St. Elizabeth's Hospital, dating to January 1946, and encompasses a total of 12,995 live births (a rate of 7.7%).

It is obvious that the validity of an accepted indication for the performance of cesarean section does not always exist to the same degree in different patients. Therefore, the decision for its use in an individual situation would preferably be based on an assay of its potential in realizing the objectives desired, rather than on a study of results obtained from its performance on the basis of diagnosis of underlying obstetric pathology. This is a novel method of analysis. We have therefore divided our sections into three groups — primarily in the maternal interest, primarily in the fetal interest, or equally in the maternal and fetal interest; secondly, by classification —elective, selective, or emergency.

Indications for Cesarean Section

Table 2 shows the indications for the cesarean sections in this

TABLE 2. INDICATIONS BY INTEREST IN 1000 CESAREAN SECTIONS

	%
Maternal	11.2
Fetal	34.0
Common	54.8

series. In over half both the mother and infant were involved equally in the obstetric pathology at the time of the operation. On the other hand, three times more cesarean sections were done in the hope of obtaining a live and unharmed infant than for a predominantly maternal indication. This situation never would have prevailed 50, or even 10 years ago, when this operation was a formidable procedure with a maternal mortality rate of 2.4%[2].

Classification of Cesarean Section

In Table 3 are given the three classifications — elective, selective, and emergency. The first and last designations require no definition; the selective cesarean sections were those performed when an obstetric condition made abdominal delivery seem probably, but not absolutely,

TABLE 3. PERCENTAGE OF PRIMARY AND REPEAT CESAREAN SECTIONS BY CLASSIFICATION

Classification	%
Primary (53.2%)	
Elective	20.1
Selective	18.3
Emergency	14.8
Repeat (46.8%)	
Elective	43.9
Selective	0.4
Emergency	2.5

the best way to attain our stated goal. There were 532 primary and 468 repeat operations, an incidence of 4.3% and 3.7%, respectively. It is worthwhile to note that there were almost six times more primary emergency cesarean sections than

TABLE 4. DATA OF TABLE 3, SUBDIVIDED BY OBJECTIVE

	Maternal (%)	*Fetal* (%)	*Common* (%)
Primary			
Elective	4.7	13.3	2.1
Selective	1.6	13.6	3.1
Emergency	4.5	6.0	4.3
Repeat			
Elective	0.1	0.8	43.0
Selective	0.0	0.0	0.4
Emergency	0.3	0.3	1.9
	11.2	34.0	54.8

repeat emergency procedures. This testifies to the evanescent character of many obstetric catastrophies, and is of course, a stimulus to further investigation of the probable cost of vaginal delivery where there has been a previous cesarean section.

It can be shown from Table 4 that 329, or 61%, of the 532 primary cesarean sections were done in the hope of more safely delivering a normal healthy infant in spite of the existing obstetric pathology or situation. This was about three times greater than when the existing obstetric pathology requiring cesarean section affected primarily the maternal organism. In the repeat section the majority, or 92%, were done in the corresponding interest of both, as we believe this situation to be equally dangerous both to mother and child.

Morbidity

The sire of maternal mortality in cesarean section is morbidity. In

this series, using the International Standard of 100.4°F. on any two successive days after the first postoperative day, the morbidity was 14.6%. Table 5 shows morbidity

TABLE 5. RELATION OF MORBIDITY TO INDICATION

Indication	*Cases*	*% Morbid*
Maternal	112	19
Fetal	340	19
Common	548	11
TOTAL	1000	14.6

in relation to the interest of the indications. In summary, it was no more dangerous to perform the operation in the interest of the mother than when the child was the chief concern.

CLASSIFICATION OF SECTION.

TABLE 6. RELATION OF MORBIDITY TO CLASSIFICATION

Classification	*Cases*	*% Morbid*
Primary		
Elective	201	17+
Selective	183	21
Emergency	148	18+
Repeat		
Elective	439	9+
Selective	4	50
Emergency	25	16

Table 6 shows the morbidity in relation to the classification of the cesarean section. The primary elective section has almost twice the morbidity of the repeat in the same category. Just why this is so is not clear. The selective group, done principally in the interest of the infant, shows the highest maternal morbidity. It is in this group that procrastination most often occurs, and 63% of the cesarean sections were done because of relative cephalopelvic disproportion and uterine inertia.

TYPE OF SECTION.

Table 7 re-

TABLE 7. RELATION OF MORBIDITY TO TYPE OF CESAREAN SECTION

	Total	*Morbid*	
		%	*Average days*
Lower segment	836	14	3.6
Extra peritoneal	101	13	2.4
Classical	36	14	8.0
Hysterectomy	27	44	2.8

fers to the types of cesarean section. The predilection for the lower segment operation is obvious, this type comprising 83.6% of the total. In the extraperitoneal group we have included only those cases in which the bladder was dissected from the peritoneal fold *without* puncture of the latter, regardless of subsequent repair, either before or after incision into the uterus. The average number of days of morbidity in each type is of interest to those who advocate the extra-peritoneal approach for infected or potentially infected patients. Although the basic morbidity rate for the extraperitoneal cesarean section is the same as the low segment operation, the true superiority of the former is indicated by a 33% decrease in duration of morbidity. 65% of the extraperitoneal operations were in the selective or emergency classification with their higher morbidity rate. Of the classical sections, 26 were by choice of the operator and 10 were by necessity, because of adhesions of large veins covering the lower uterine segment. The outmoded classical procedure produced the same total morbidity rate, by patient, as did the other two types, but three times the morbidity by days of the extraperito-

neal, and twice that of the low segment operation. Hysterectomy for infection is a valid procedure, as its morbidity by days indicates. Hysterectomy in our hospital is done only on grave indication, which accounts for the high morbidity rate by case.

NUMBER OF PREVIOUS SECTIONS. Table 8 indicates that the number of previous sections did not affect the morbidity rate. The uteri in this series were subject to 744 incisions previous to the start of this series and constitute a group of 1212 repeat sections without a maternal death. We believe that the use of the lower uterine incision makes sterilization of the patient unnecessary. Irving, with an incidence of 54.6% of classical cesarean sections, reported a 24.4% sterilization rate, of which 66.4% were on the basis of previous section, and included 12 ruptured uteri, all of which were removed.[3]

TABLE 8. RELATION OF MORBIDITY TO NUMBER OF PREVIOUS CESAREAN SECTIONS

No. of previous cesarean sections	*Cases*	*% Morbid*
0	532	19
1	278	10
2	133	13
3	37	11
4	13	15
5	5	0
6	2	0
TOTAL	1000 (744 previous sections)	

In patients with no previous sections, 19% morbidity; with one or more, 10% average morbidity.

ETIOLOGY. In all cesarean section studies, hemorrhage, shock, sepsis, and pulmonary emboli account for the major portion of the maternal mortality and morbidity. In labors lasting over 12 hours before operation the morbidity rate doubled, and with ruptured membranes of the same duration it almost tripled. Postoperative antibiotics, principally penicillin, were used in all morbid cases and in a total of 431 cases postoperatively as a prophylactic measure.

Table 9 shows that shock occurred in 8.5% of the cases. It was twice as frequent when the operation was done for common maternal and fetus indications, and was three times more frequent in the emergency operation. Eighty-nine patients were transfused without untoward reactions. The presence of shock doubled the maternal morbidity rate. It is obvious that no cesarean section should be started without at least one pint of properly matched blood available.

TABLE 9. SHOCK IN 85 CASES OF MATERNAL MORBIDITY (ALL INDICATIONS)

Classification	*No. cases*
Primary	
Elective	14
Selective	9
Emergency	26
Repeat	
Elective	32
Selective	0
Emergency	4
TOTAL	85

Indications: Maternal, 20; fetal, 20; common, 45.

TABLE 10. CAUSES OF MORBIDITY (INTRINSIC SEPSIS)

Complication	*No. of cases*
Paralytic ileus	58
Endometritis	9
Parametritis	1
Wound sepsis	6

Of the 146 morbid cases it was possible to determine the cause of morbidity in 132, as indicated in

Table 10. Sixty-eight of these involved uterine or abdominal sepsis. In patients with this complication, the two most common indications and classifications were primary selective and repeat elective operations. The interesting fact that Wagensteen suction was not needed in any case successfully done extraperitoneally, indicates minimal peritoneal irritation with this procedure.

Uterine Rupture

The 3 ruptured uteri in this series all occurred in patients with a previous classical section. Two resulted in the loss of the uterus, and all 3 occurred before 38 weeks after the last menstrual period, which is the time of choice for repeat sections. Two of the three infants were stillborn and one, at 36 weeks of age, survived. It has been adequately shown that the classical scar has twice the potential of rupture than does the lower segment scar, which is one more reason against the use of the classical section.

Hysterectomy

Table 11 shows that of 27 hysterectomies, 14 were primary and 13 in repeat cesarean sections. Ten were in selective or emergency procedures and 4 were associated with afibrinogenemia. In 7 the indication was maternal; fetal in 4; and in 16 both mother and infant were involved equally. The hysterectomy rate for pathologic uteri was 2.7%. Twenty of these women were over 35 years and 25 were over 30.

TABLE 11. INDICATIONS FOR HYSTERECTOMY

	No. of cases
Fibroid uterus	4
Ruptured uteri	2
Poor scar	6
Hemorrhage	11
Couvelaire uterus	3
Placenta accreta	1

Of the 6 done for poor scars, 5 were lower segment and one classical. One patient had 3 previous sections; 1 with delayed hemorrhage from the scar, had 1 previous section; and 4 had 2 previous sections. Of the latter group, 2 were in association with placenta previa. In this group of repeat sections, 735 out of 744 previous uterine incisions were adequate at the time of the latest operation. Four of the 9 inadequate scars were of the classical type and 3 of the 5 remaining low segment types were complicated by further obstetric pathology. Eleven uteri were removed for lack of tone resulting in hemorrhage. This is a much higher incidence of hysterectomy for hemorrhage than in patients delivered vaginally—apparently the surgically exposed uterus is more vulnerable to the fears of the obstetrician. The lower segment operation is more liable to incur this complication because the uterine operating site distorts the normal axis of the uterus, contributing to the atonicity. Seven of these were primary sections. This is another reason why preoperatively typed blood is mandatory for all contemplated cesarean sections. The morbidity in our series for hysterectomy was high, and the reason lies in the indication for the operation. The true value for the procedure is indicated in the low number of

days of morbidity, which almost approximates that of the extraperitoneal cesarean section.

Maternal Mortality

It is obvious that our staff practically always follows the dictate of once a cesarean section, always a cesarean section, and in our opinion the proponents of delivery through the vagina following cesarean section in selective cases have not collected sufficient material to prove otherwise.

In this series of 1000 consecutive cesarean sections, 3 mothers died, a mortality rate of 0.3%. The first was a true obstetric death in a patient 28 weeks pregnant who had had a previous myomectomy. The indication for the section was possible rupture of the uterus. A thorough work-up to rule out possible extraneous cause, from flat abdominal plates for the possibility of a ruptured viscus through amylase tests to rule out pancreatitis, left no other possible diagnosis. The uterus was intact, and after negative investigation of its interior for a possible nontoxic separation, there developed intractable generalized hemorrhage resulting in death. The blood findings in this case led to the theory of possible afibrinogenopenia, especially related to pregnancy, and the ultimate discovery of the validity of such a hypothesis one year later.[5] The second death was in a patient who proved to have a complete volvulus of the small bowel and the cesarean section was done merely to present to the abdominal surgeons a field in which to evaluate the most important preoperative findings of free chyle in the peritoneal cavity. The third section ending fatally was an elective procedure done at term, before labor, to salvage a normal baby in a woman in extremis from rupture of a congenital cerebral aneurysm. This death is reported in detail elsewhere.[7] None of the 3 deaths was in any way associated with the technic of cesarean section, and all were emergency procedures. Two were primary sections; the indications were maternal, fetal, and of equal interest. Only in the case of the vascular accident was an infant salvaged.

Neonatal Mortality

Table 12 shows the indications and classifications of cases in which neonatal death occurred. Corrected, for 8 cases each of erythroblastosis and major congenital anomalies incompatible with life, the rate was 44 per 1000 sections. The emergency procedure accounted for 61% of the infant mortality. Primary and repeat elective sections had about the same fetal loss —a reminder that as primary elective sections are generally performed at term and repeat sections at 38 weeks there is another factor besides fetal weight influencing fetal mortality in delivery by this procedure. It is recognized that, without complicating obstetric pathology, the safest method of delivery is via the natural passage.

In 565 elective operations in this series, which involved, therefore, existing but only potential obstetric defection, the neonatal loss was 7 infants of those weighing 2500 Gm. or more, without congenital

deformity. This constitutes a fetal

TABLE 12. INDICATIONS AND CLASSIFICATIONS FOR CESAREAN SECTIONS RESULTING IN NEONATAL DEATH[a]

	Total cases	*No.*	*%*
Maternal indication	112	19	17
Fetal indication	340	9	3
Common indication	548	16	3
TOTALS	1000	44	
Primary			
Elective	201	5	2.4
Selective	183	2	1.9
Emergency	148	22	15
Repeat			
Elective	439	10	2.3
Selective	4	0	0
Emergency	25	5	20
TOTALS	1000	44	

*Corrected for congenital anomaly and erythroblastosis.

risk of about 12 infants for every 1000 elective sections, and should serve as a guide in assaying the potential risk of an obstetric situation versus the hazard to the infant of delivery by the abdominal route. Six of these deaths were due to abnormal pulmonary ventilation and 1 to anoxia. The duration of labor or rupture of membranes prior to operation were not important factors—in contrast to maternal morbidity under the same circumstances—and the primary elective section is probably best performed after about 6 hours of labor or 12 hours after the membranes rupture, in the interest of conditioning the infant to extrauterine existence. Half the neonatal deaths were associated with antenatal maternal hemorrhage. Maternal morbidity doubled when the obstetric situation was severe enough to cause neonatal death.

Table 13 indicates that the number of previous sections did not influence neonatal mortality rate. As noted above, repeat sections did not increase the maternal risk.

TABLE 13. NUMBER OF PREVIOUS SECTIONS IN RELATION TO NEONATAL MORTALITY (UNCORRECTED)

No. of previous sections	*Neonatal deaths*	*Stillborn*
0	36	15
1	11	9
2	6	3
3	5	0
4	1	0
5	1	0
TOTALS	60	27

PREMATURITY. The incidence of prematurity by weight was 16.7%, over twice the usual hospital rate, as indicated in Table 14. Sixteen

TABLE 14. INDICATIONS AND CLASSIFICATIONS OF CESAREAN SECTIONS RESULTING IN PREMATURE INFANTS

	Total	*No.*	*%*
Maternal indication	112	42	38
Fetal indication	340	48	14+
Common indication	548	77	14+
TOTALS	1000	167	
Primary			
Elective	201	28	17
Selective	183	18	11
Emergency	148	67	40+
Repeat			
Elective	439	37	22
Selective	4	3	2
Emergency	25	14	8+
TOTALS	1000	167	

of the 167 prematures were stillborn; two-thirds were under 38 weeks' gestational age. Two-thirds were in the primary section group and almost one-half were associated with antepartum maternal hemorrhage. Thirty-two of the 151 live born prematures died neonatally, accounting for 63% of the total neonatal mortality. Four of these deaths were from a major congenital anomaly or erythroblastosis.

It is noteworthy that 39% of the prematures were in the elective procedures, further indication that the estimate of fetal size in utero is hazardous at best. As indicated above, in primary elective sections it is best to have some labor. In repeat elective sections, inasmuch as those uteri foreordained to rupture in a given pregnancy generally do so by 38 weeks, there should be no hesitancy in waiting further in the interests of obtaining a more mature infant. The corrected neonatal death rate for prematurity was 19%, and 43% of these deaths were associated with antepartum maternal hemorrhage. About 50% of the prematures were the products of obstetric pathology jeopardizing both the infant and the mother equally before birth.

Table 15. Indications and Classifications of Cesarean Sections Resulting in Stillbirths

	Antepartum	*Intrapartum*
Maternal indication	23	3
Fetal indication	0	1
Common indication	0	0
Totals	23	4
Primary		
Elective	0	0
Selective	0	1
Emergency	14	2
Repeat		
Elective	4	0
Selective	0	0
Emergency	5	1

Fetal Mortality

Table 15 shows the indications and classifications for the cesarean sections resulting in the 27 stillborn infants in this series. Over half the mothers had toxemia; 20 of the infants were under 38 weeks' gestational age. Only 1 stillborn was subjected to a labor of 18 hours or more, and only 1 infant was lost during the cesarean section procedure, which was done primarily for its benefit. The maternal morbidity was two and a half times as great as the average when the infant was stillborn.

Summary

The factors resulting in the amazing reduction in maternal mortality in the era of modern obstetrics is reflected in the increased safety of cesarean section with an increase in the utilization of this method of delivery. Neither the true incidence of necessity nor the point of diminishing returns has been determined.

The apogee of obstetric practice is the delivery of a healthy infant by a healthy mother and until this is accomplished the maternal-fetal relationship is an insoluble equal partnership.

The motivation to perform a cesarean section is not always the diagnosis of obstetric pathology but rather the reflection of this defection on maternal or fetal welfare, or both. One thousand cesarean sections in the modern era have been presented, which were evaluated on the basis of the immediate purpose of the operation rather than obstetric diagnosis.

Primary cesarean sections were done three times more commonly in the fetal than in the maternal interest, but it was no more dangerous to perform the operation in the interest of the mother than in that of the child.

The number of previous cesarean sections did not increase the

morbidity rate of the present section, nor was the neonatal mortality rate increased by the number of previous sections.

The risk to a normal infant weighing 2500 Gm. or more, being born to a mother with existing but only potential obstetric pathology in elective section, is 12 per 1000.

Sterilization after cesarean section is unnecessary. When it is done, it is either due to the sacrifice of medical integrity to the unwarranted assumption of a "social indication," or is a result of the failure to employ modern surgical technics.

Four hundred and eighteen patients had a repeat section after this study had been completed (Table A), with a 3.1% maternal morbidity rate and no maternal mortality. One uterus ruptured at 32 weeks in a patient who had had 1 previous classical cesarean section. The entire group is comprised of a total of 1630 repeat sections without maternal mortality and 1208 intact uteri, at the time of subsequent section, out of 1212 subjected to previous incisions. There was 1 inadequate scar in a third section, which required hysterectomy at ensuing section. The four ruptured uteri in the entire series all followed 1 previous classical section and all occurred before 38 weeks gestation.

Addenda

TABLE A. REPEAT CESAREAN SECTIONS NOT INCLUDED IN STUDY

No. previous cesarean sections	*No. cases*	*No. cases of mat. morbidity*	*Neonatal deaths*
1	236	4	3
2	134	7	0
3	39	1	0
4	6	1	0
5	1	0	0
6	2	0	0
TOTALS	418	13	3

1. COLVIN, E. Expansion versus restriction of cesarean section. *Am. J. Obst. & Gynec. 64*:473, 1952.
2. DENORMANDIE, R. Five year study of cesarean section in Massachusetts. *New England J. Med. 227*:533, 1942.
3. IRVING, F., Cesarean section at Boston Lying-in Hospital. *Am. J. Obst. & Gynec. 50*:660, 1945.
4. LAHEY, F., and RUZICKA, E. Experiences with cardiac arrest. *Surg. Gynec. & Obst. 90*:108, 1950.
5. MOLONEY, W., EGAN, W., and GORMAN, A. Acquired afibrinogenemia in pregnancy. *New England J. Med. 240*:596, 1949.
6. National Office of Vital Statistics, Federal Security Agency, Washington, D. C.
7. SULLIVAN, C., *et al.* Spontaneous cerebral hemorrhage of congenital origin in pregnancy. *Postgrad. Med. 14*:329, 1953.

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What Must the Cancer Patient Be Told?

JOHN J. LYNCH, S.J.

CATHOLIC PHYSICIANS in general have no quarrel with that paragraph in our *Ethical and Religious Directives* which reads as follows: "Everyone has the right and duty to prepare for the solemn moment of death. Unless it is clear, therefore, that a dying patient is already well prepared for death, as regards both temporal and spiritual affairs, it is the physician's duty to inform, or to have some responsible person inform, him of his critical condition." Such are the values at stake in the face of approaching death that it is not too difficult to discern the doctor's primary obligation in these circumstances. Whatever doubts may be occasioned by the explicit wording of the directive are amply clarified by the comments of Fr. Gerald Kelly, S.J., in *Medico-Moral Problems*, II, 7-9, and in LINACRE QUARTERLY, August 1955, 95-97.

But not so evident perhaps is the answer to a further question which is not expressly provided for in the Directives and which is being asked with increasing frequency. Should the cancer patient be told the nature of his disease? Is there any moral principle which obliges a doctor to reveal his diagnosis of cancer, or is he justified in withholding that information even if the patient asks the question direct?

Some doctors have solved the problem for themselves in universal terms, and maintain that the fact of cancer should never be revealed to a patient, even if a lie is necessary in order to conceal the truth.[1] To my knowledge, only one professed ethician (not a Catholic) has defended the other extreme and insisted that all diagnostic data belongs to the patient by strict right and cannot licitly be withheld from him.[2] Catholic moralists who have considered the problem adopt a more conservative position, and prefer not to speak *a priori* of either alternative in terms of strict obligation. They exclude the lie, of course, from among the legitimate means of concealing the truth. But they do make provision for a choice according to the circumstances of individual cases. And the ultimate decision — whether tactfully to reveal the truth or to withhold it by some legitimate evasion — they leave to the doctor's prudent judgment as to what is best for the individual patient.[3]

One gets the impression, however, that doctors are not always

[1] For one sampling of varied medical opinion on this question, cf. *GP*, September 1954, 74-84.

[2] Joseph Fletcher, *Morals and Medicine*, Ch. 2, "Medical Diagnosis: Our Right to Know the Truth."

[3] John A. Goodwine in *America*, 28 May 1955, 236-38; Gerald Kelly, S.J., in *Linacre Quarterly*, August 1955, 96, and *Medico-Moral Problems*, II, 8; Jules Paquin, S.J., *Morale et Médecine*, 409; G. Payen, S.J., *Déontologie Médicale*, 125-26.

entirely satisfied with such a solution. Some seem to suspect the moralist of straddling the issue and of foisting upon others a responsibility which is properly his own. They press for a less ambiguous answer, a more automatic rule-of-thumb, apparently forgetful of the fact that the norm proposed by moralists for this situation is the very one which physicians instinctively follow in ordinary circumstances, to the mutual satisfaction of both themselves and their patients.

How does the doctor usually decide which details of diagnosis to share with his patient and which to withhold? Invariably he has recourse to the patient's own best interests. Because, for example, their intelligent cooperation is clearly necessary for successful therapy, the cardiac, the diabetic, the epileptic, and the victims of other curable or controllable ailments are instructed in some detail as to the nature of their afflictions and in the precautions which must be taken to cope with them. Anything less would be professionally inexcusable, since it is altogether clear in such cases that to keep the patient in ignorance would be to defeat the immediate purpose of the doctor-patient relationship, namely, the cure or control of disease. And in accordance with the same norm, other details are frequently not disclosed, either because they would be of no particular benefit to the patient or because, through misunderstanding or exaggerated concern on his part, therapy would be thereby more hindered than helped. In any case it is the physician who takes the responsibility of deciding how much of his diagnosis to reveal and how much to withhold — always with the best interests of the patient at heart. Patients who have confidence in their doctors, and who are able to judge their own cases objectively, would be among the first to agree that adherence to some such norm is ultimately to their best advantage and most compatible with their reasonable wishes.

Consequently it would seem entirely consonant both with good medical practice and with sound morality to express some such principle as this with regard to the patient's right to the whole truth: the patient's reasonable claim to diagnostic data is not absolute, but is qualified by his own presumed intention to receive maximum benefit from medical treatment. In other words, he rightfully expects and is entitled to such information from his physician as can be judged truly necessary or useful for his own total well-being. On the other hand, he is presumed not to desire knowledge which would prove more detrimental than beneficial. Any demand for such knowledge may be considered unreasonable and may be evaded, if possible, by any legitimate means.

Sometimes the only possible difficulty in applying this principle would be a physician's blindness to certain objective values. Thus on the supposition of approaching death, for example, all other considerations yield to the spiritual good of the patient, to his right and obligation to prepare ade-

quately for eternity. For Catholics this means ordinarily the opportunity of receiving the last sacraments while still in possession of their rational faculties. For non-Catholics likewise it means a chance to conjure with the realization of death's approach and to prepare themselves in whatever manner their own religious convictions and God's grace may suggest. No other consideration of itself outweighs the spiritual importance of realizing that the time for repentance, for acts of virtue, for grace and merit, is drawing to a close. Chiefly for that reason, because the patient's highest spiritual interests so clearly require an awareness of approaching death, moralists can speak without hesitation in terms of obligation on the doctor's part to see to it that his patient is provided with that knowledge.

But when it comes to the question merely of identifying for a patient the precise nature of his illness, the issue is not always so clear-cut. The difficulty then lies in determining whether the patient's welfare is truly best served by imparting that information or by withholding it. For on the one hand, once the patient is aware that his illness is fatal, it is not likely that ignorance of its more specific nature will have serious harmful effects on his spiritual or material well-being. (Or if cancer is curable, therapy will usually not be hindered merely because some euphemism is substituted for the word "cancer.") On the other hand, it is not always possible to predict just what psychological effect, good or bad, knowledge will have. Some take the realization of cancer courageously and even cheerfully; others may tend to despondency and despair. For some the dread word would be a crucifixion; for others, knowing the worst can be a distinct mental relief, a comfort of sorts, and perhaps a welcome instrument of grace and merit. Seldom can one be sure beforehand just what reaction will occur. It is because of the uncertainties involved in most such cases that moralists cannot speak in universal terms of obligation on a physician's part to reveal a diagnosis of cancer. That decision would appear to be usually a question of the preferable thing to do, and not necessarily a matter of moral right and wrong.

Hence a doctor's strict moral duty to inform the patient would seem to include only (1) information necessary to the patient in order to insure successful therapy, and (2) foreknowledge in proper time of approaching death. The decision to communicate further diagnostic details need not be dictated by a sense of grave obligation, though it may suggest itself as the more humane thing to do in some circumstances. When an emotionally well-balanced victim of cancer expresses a sincere and rational desire to know the truth—especially if he be a person of strong faith—it can prove psychologically advantageous to all concerned that the truth be told him. If no request for the information is made, it is safe to presume that the patient either prefers not to know or is not particularly interested; and since he has no obliga-

tion to inform himself of that fact, the physician is justified in maintaining silence. And if a doctor has positive reason to believe that only harm would result from the knowledge, then evasion of the issue by any legitimate means is the proper procedure.

In every case the norm should be the same, namely, the individual patient's best interests insofar as they are humanly discernible. But the ultimate decision should not be the same in every case, since what is good in this regard for some will be bad for others, and *vice versa*. Hence one thing which doctors should avoid is the application of one and the same prefabricated decision to every case they encounter. Rather they should make a reasonable attempt to predetermine whether the truth about cancer will be of benefit or harm to the individual patient, and on this altruistic basis formulate an *ad hoc* judgment.

The moral principle involved is altogether clear: act always in the best interests of the patient. Its proper application to this problem depends upon a doctor's correct sense of values and his prudent discernment.

* * * *

ST. PEREGRINE, THE CANCER SAINT

St. Peregrine (rhymes with ter'rapin) was converted by St. Philip, O.S.M. He entered the Order of the Servants of Mary in 1283. Then for 62 years, Peregrine labored with the sick and did incredible, voluntary penance in religious life in reparation for a tempestuous youth. God permitted a cancerous growth to gnaw away at one of his legs. Amputation was deemed necessary. A miraculous cure the night before the scheduled surgery removed all trace of the malady.

His feast day is May 2 and God's power has been manifested in sudden and miraculous cures affected through Peregrine to win him the title of official patron of cancer victims. For centuries Europeans have been loyally devoted and have confidence in this Saint.

In America the true mission is not necessarily to heal all cancer victims but rather to teach the value of pain so that their sufferings may not be wasted, with no profit to them. Discouragement should not follow if St. Peregrine does not miraculously effect a cure. Who knows? Maybe God is saving that miracle for someone whose faith is less strong . . .

Further information may be had by writing to The St. Peregrine Center, 3121 W. Jackson Blvd., Chicago 12, Illinois. Booklets, statues, medals, prayer leaflets, and holy cards are available.

Fewer Malpractice Claims—Via Our American Way

Consent for Treatment

T. Raber Taylor, A.B., LLB.

Do you recall the front page story about the $33,700.00 malpractice verdict for a sterilization operation? The jury believed the patient's claim that he only consented to a circumcision.[1] Did you hear of the $100,000.00 malpractice claim for removing a woman's right breast on an indication of cancer? She claimed she consented only to a bladder and rectal operation.[2] You probably read of the $250,000.00 claim for removing a woman's left ovary and other reproductive organs. She claimed she consented only to the removal of her right ovary.[3]

These claims, and others, prompted the request for a review of American law on patient's consent. Will this review lessen the number of malpractice claims? We all hope so. Our review of American law properly begins with the Declaration of Independence. It expresses our American philosophy of law. Its philosophy has bearing, not only on the rights of the citizen against the state, but also and equally, on the rights of citizens between each other. It has application to questions involving the rights of patient and physician. Our American philosophy of law is expressed in these familiar words:

> "We hold these Truths to be self-evident, that all Men are created equal, that they are endowed by their Creator with certain inalienable Rights, that among these are Life, Liberty, and the Pursuit of Happiness. That to secure these Rights, Governments are instituted among Men, deriving their just Powers from the Consent of the Governed; * * *"

You spot the three key philosophical and ideological concepts—

First, All men are created and endowed by their Creator with inalienable Rights.

Second, Man's right to life is Creator endowed.

Third, Consent is given to Government to secure this Right to life.

These concepts indicate to doctors that physicians, like government, are instituted to make secure man's right to life. To us they also point that, like government, physicians derive their authority from man's consent. Our American law, therefore, starts with the premise of self-determination. If a physician judges a

[1]The Denver Post, Friday, Oct. 31, 1952. On appeal to the Colorado Supreme Court, the case was reversed and sent back for new trial as to one of the doctors.

[2]Denver District Court, Civil Action A-70645. Summary judgment entered for the surgeon.

[3]The Denver Post, September 26, 1952. The jury rejected her claim. Denver District Court, Civil Action A-85379.

certain treatment or operation is medically indicated, does our law permit the physician to impose his judgment on the patient? No. Each man is master of his own body. He may, if he be of sound mind, expressly prohibit the performance of life sustaining treatment. All of us agree that the physician may not obtain the patient's consent to treatment by any form of double-talk, artifice, constraint, or overreaching. A distasteful example may highlight this principle for us. A surgeon told his patient that he intended to undertake minor repairs of her cervix. He planned, however, to remove her uterus and reproductive organs, but he did not disclose his plan to her. She consented to the cervical repair, but he performed the planned removal. The court sustained a verdict against the doctor because there was no consent to the operation performed.[4]

Physician respect for the Creator-given right to life is the key to obtaining, or to use the Declaration of Independence word, "deriving" patient consent. Every patient, including the so-called charity patient, is a person. As a person he has both the right and the duty to care for his health and life. When a physician treats a patient he is simply the patient's agent, exercising the patient's own right of preserving and securing his life.

Our American law, like the laws of other nations, long ago established the principle and presumption that every adult of sound mind has enough intelligence to understand the meaning of a consent to treatment or operation. This principle and presumption places on the physician a twofold personal duty:

(1)—to explain to his patient the general purpose, extent, and risks, if any, of the prescribed treatment or operation; and

(2)—to be certain the patient understands, and then freely consents.

The physician's careful discharge of this duty to every patient is a basic defense against malpractice claims. When this double duty of the physician has been discharged, and when and if the patient consents, then, and only then, may the physician act. Usually this personal duty is complied with simply and without formality or written record. Sometimes a regular patient, with well-founded confidence in his physician, wants to consent to the necessary doctoring without any explanation from the doctor. His physician may act on such consent. Consent also may be reasonably presumed in cases of emergency, either where an unconscious patient is unable to give consent, or where precious seconds must be used to stop the outflowing of life.

Serious Illness or Surgery

Where a serious illness is being treated, or surgery is prescribed, physician candidness is required by our laws[5] as well as by our

[4]Pratt v. Davis, 224 Ill. 300, 79 N. E. 562; Griffin v. Bles, 202 App. Div. 443, 194 N. Y. S. 654.

[5]Malpractice and the Physician, Louis J. Regan, M.D., LL.B., 147 J.A.M.A., pp. 54-59 (Sept. 1, 1951).

medical ethics[6]. The permit of a patient, without the physician's disclosure of the material facts due him, may prove in fact to be no consent. The physician-patient relationship is a personal and intimate one. It involves an element of trust and confidence. An obligation of utmost good faith exists and requires the physician to make the fullest possible disclosure about the **risks** of any prescribed treatment. To illustrate, a man went to his doctor complaining of a swelling in the palm of his right hand. The doctor diagnosed it as a Dupuytren's contracture and recommended corrective surgery. His doctor did not, however, disclose the considerable risk that the operation might fail and leave the patient's hand worse than before. The patient consented to the operation which, according to the evidence, he would not have done had he known the odds of failure. The operation was skillfully performed, but failed to achieve the expected result. The patient was left with greater disability than he had originally. A jury verdict against the doctor was affirmed. The skillful performance of the operation did not, ruled the Supreme Court, excuse the doctor who had breached his duty to make a full disclosure of the surgical risk to the patient as an incident to gaining his enlightened consent.[7]

Our Government in the Nuernberg Medical Trials has given implicit declaration that man's Creator-endowed rights to life are inalienable. It has also made express application of the principle that the physician's authority to treat is derived from the patient's **consent.** Although the following noteworthy statement of law was applied to experiments on humans it reflected a consensus of our American decisions in cases not involving experimentation. Because it was adopted by the Tribunal for all participating nations, it is a landmark decision in international law. In part, it reads:

> "The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.
>
> "The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity."[8]

[6]The Principles of Medical Ethics, A.M.A. 1949, Article III, Secs. 1 and 2.

[7]Schaendorff v. The Society of the New York Hospital, 211 N. Y. 125, 105 N.E. 92; Kinney v. Lockwood Clinic, Ltds., 4 D.L.R. 906 (1931). See Bailey v. Harmon, 74 Colo. 390, 222 Pac 393 (1923).

[8]II Trials of War Criminals Before the Nuernburg Military Tribunals, U. S. Government Printing Office, "The Medical Case." pp. 181-182.

When the physician has been candid and the patient comprehends and consents to the prescribed serious treatment or surgery, then a witnessed memorandum of the consent should be made. The law requires comprehending consent of the patient. The law does not **require** that it be in writing. "The business of getting signed authorization on a formal instrument is but a rule of professional custom, laudable in every respect, but it is not required by any law."[9] The written form is obtained for the physician's protection. A form will be good protection only insofar as it is a memorandum reflecting what the doctor explained, the patient knew, and to which the patient consented. Emphasis on the **form**—the consent paper—has detracted from the **substance**—a complete comprehending clear consent. If exploration, or an incidental operation is contemplated, the patient should understand and consent.

"Blanket" Forms Are Not Enough

The best memorandum reflects the oral explanation of the physician, the consent of the patient, and the patient's witnessed signature. A permit that specifies neither the kind of treatment or surgery, nor who is to do it, leaves the consent ambiguous. This ambiguity may create misunderstanding. Naturally, the nature of the treatment or operation need not, and should not, be described in technical terminology. Again, if exploration, or an incidental operation is contemplated, the consent should say so and permit it. If a blanket form of consent is to be used, it should at least name the doctor and authorize him to give the treatment or perform the operation that, in his judgment, he deems necessary. A consent form signed by a patient who does not know what he is signing is of doubtful value. Blanket, or "blunderbuss" consent forms, claiming, to authorize any and all procedures by any and all staff members and agents, are undesirable. They are a weak defense against the patient's statement that different treatment was received than he agreed to. Further, such forms violate the doctor-espoused principle of giving every person his free choice of physician. Less reliable, if at all reliable, are the small print consent forms obtained at the admission desk. No explanation is given to the patient. Often there is not a true opportunity for the patient either to read or to understand what is being signed.

Should all routine and blanket consent forms be discontinued as useless? No, but it is hoped that our review will stimulate an improvement in the procedure for obtaining consent. It is also hoped the review will heighten the physician's awareness of his personal obligation to explain the treatment, its extent, and the risks, if any, at the time he gets the patient's consent.

By way of conclusion, let us each bear in mind the paramount

[9]Maercklein and Postma v. Smith, 129 Colo. ____, Colorado Bar Association Advance Sheet, Vol. 6, No. 9, page 188 at 191; 266 Pac. (2d) 1095.

concept of our American law. Each man is endowed by his Creator with the inalienable right to life; even to secure a patient's right to life, his consent is needed by his physician.

[Mr. Taylor gave this as the Postgraduate Lecture, Mennonite Hospital and Sanitarium, La Junta, Colorado, Feb. 21, 1955. It was first printed in **The Rocky Mountain Medical Journal,** May, 1955. We acknowledge kind permission to republish in LINACRE QUARTERLY.]

The Doctors' Guild

St. Luke unto the doctors on a Christmas day decreed:
"The doctors shall be gentle and the Master's words shall heed,
'The works which I do they give testimony of Me.'
Let the world see in your diligence, the glory of Calvary,
And guided be your hands, let their sacredness reveal;
They are worthy to be clasped in His, in His love to heal.
For holy is your trust, blessed your mind in thought applied,
You serve the sick and suffering, for these He died.
And all your lives be faithful to the least of all mankind,
That to you His promise: 'Blessed of My Father!' in eternity will bind."

G. K. CHESTERTON

Doctors Ask These Questions

GERALD KELLY, S.J.

In the August number of THE LINACRE QUARTERLY *we began the publication of answers to questions that are frequently asked at informal discussions with doctors and medical students. The answers to several more such questions are given here. Some of the answers might be more complete; but it seemed to me that whenever a question is discussed in one of the booklets entitled* MEDICO-MORAL PROBLEMS *it would be sufficient to give a brief answer, with the pertinent reference to the more complete treatment of the problem.*

5. Many of our state institutions sterilize inmates because of congenital mental diseases. What is the moral refutation of this?

This is what is called *eugenic* sterilization; that is, sterilization for the good of the race. The general objectives of those who advocate such sterilization are to have a more healthy citizenry and to reduce tax burdens. We have no moral objection to these purposes; rather, we praise them. The moral refutation, therefore, is directed rather against the means chosen to attain the objectives and against the philosophical notions of those who recommend these means.

The actual refutation may follow one or both of two lines. It might be *practical*, showing that sterilization, even if it were not immoral, is ineffective for attaining the objectives. Or it might be *philosophical*, showing that, even if the means were effective, it is immoral and therefore may not be used.

It would obviously be impossible for me to give a complete practical refutation here. For this kind of refutation, I would strongly recommend that doctors interested in this problem read the splendid treatment of eugenic sterilization by Father Charles J. McFadden, O.S.A., in the third edition of his *Medical Ethics* (Philadelphia: F. A. Davis Co., 1953), pp. 302-324. With scholarly objectivity, Father McFadden gives the supposed case for, as well as the case against, eugenic sterilization. One very impressive practical point, too often overlooked, is that a policy of sterilizing all mental defectives with a hereditary defect would make but little impression on future generations because by far the larger percentage of possibly hereditary cases would trace from "carrier" parents who are themselves normal and thus would not be sterilized.

These practical arguments must, no doubt, be discussed. Nevertheless, it is imperative for us to note that, even if it could be proved with certainty that a policy of eugenic sterilization would eliminate all future hereditary defectives, the procedure would still be wrong on

principle. It is a direct sterilization, a contraceptive procedure; consequently all that has been said in the article, "Catholic Teaching on Contraception and Sterilization, "*Medico-Moral Problems,* V, 22-36, would apply here. Eugenic sterilization has been frequently condemned by the Holy See. The most important and forceful of these condemnations is in the encyclical on Christian Marriage. I shall cite these paragraphs of Pope Pius XI presently, but before I do so I should like to call attention to certain points, certain "background material," that even Catholic doctors are apt to overlook.

The program for eugenic sterilization was conceived in a materialistic atmosphere. The proponents show no realization of the fact that children are born not only for earth but for heaven. Nor do they show any realization of the benefit that accrues to human nature from caring for and protecting the weak. Many of them do not care about sin—e.g., fornication; all they wish to do is prevent the social consequences. One exponent of compulsory eugenic sterilization who is frequently cited with awe, as if this were indeed the last word to be said on the subject, is Justice Oliver Wendell Holmes, Jr. It is not added that for Holmes, who is unfortunately the god of lawyers and legislators in the United States, the essence of law is physical force. He had no belief in natural law, no use for the principle that human life is sacred and inviolable.

The foregoing points are, as I said, merely background material for understanding the philosophy behind the program for eugenic sterilization. In this program they include both *involuntary* sterilization, that is, sterilization without the consent of the subject, and *voluntary* sterilization, which supposes the subject's consent. In the encylical on Christian Marriage, Pope Pius XI gives the essential arguments against both these points. First he states very clearly that the state has no right to mutilate an innocent man; then he adds that the individual himself has no right to give such a consent. The pertinent paragraphs read as follows:

"Public magistrates have no direct power over the bodies of their subjects; therefore, when no crime has taken place and there is no cause present for grave punishment, they can never directly harm or tamper with the integrity of the body, either for reasons of eugenics or for any other reason. St. Thomas teaches this when, inquiring whether human judges for the sake of preventing future evils can inflict punishment, he admits that the power indeed exists as regards certain other forms of evil, but justly and properly denies it as regards the maiming of the body. 'No one who is guiltless may be punished by a human tribunal either by flogging to death, or mutilation, or by beating.'

"Furthermore, Christian doctrine establishes, and the light of human reason makes it most clear, that private individuals have no other power over the members of their bodies than that which pertains to their natural ends; and they are not free to destroy or mutilate their

members, or in any other way render themselves unfit for their natural functions, except when no other provision can be made for the good of the whole body."

6. Is contraception wrong only for Catholics?

A fair answer to this question requires a distinction between *what is* right or wrong; and *what people think* is right or wrong. Since contraception is intrinsically evil, it is always wrong for everyone, Catholic or non-Catholic. There seems to be no doubt, however, that many non-Catholics think that it is not wrong in certain circumstances. These points are more fully explained in *Medico-Moral Problems,* I ("Non-Catholics and Our Code"), and V ("Catholic Teaching on Contraception and Sterilization").

7. Is there a minimum number of children that a healthy married couple are obliged to try to have?

The answer to this question also calls for a distinction: this time between the official teaching of the Church and the opinions of some theologians. Pope Pius XII stated officially that married people who choose to exercise the marital act have a duty to make some contribution to the conservation of the race. He did not try to state in precise terms the size of the family a couple should try to have, though he did clearly outline various reasons that would excuse from the duty in whole or in part, and thus allow for the legitimate practice of rhythm.

Father E. C. Messenger once voiced the opinion that a fertile couple should have at least four children. This statement was made even before the address of Pope Pius XII on the moral problems of married life. After the papal address, the present writer suggested that a good practical estimate of the duty to procreate might be four or five children. At a meeting of the Catholic Theological Society of America, the majority of theologians who discussed this problem thought that the estimate of four or five children might be taken as a safe working norm for the obligation.

To put it briefly: no one can say with certainty just what the minimum obligation is. But, unless the Holy See would make some further pronouncement on the question, the opinion that a family of four or five children would normally satisfy the duty of procreating may be safely followed. It should be noted however, that generally speaking these discussions about "numbers" are rather theoretical because in actual cases many factors have to be considered in judging the licitness, and especially the advisability, of practicing the rhythm. I say that the discussions are "generally speaking" rather theoretical, because in some individual cases the estimate of numbers may be very helpful to a couple who wish to have some norm for the reasonable spacing of children.

For more complete details on this topic, see "Official Statement on Rhythm," *Medico-Moral Problems,* IV, 29-34, and "The Doctor

and Rhythm," *Medico-Moral Problems,* V, 37-39.

8. Who is to decide when a patient is to receive extreme unction, the doctor or the chaplain?

The chaplain is to make the decision — or the pastor of the parish in case he is to confer the sacrament. Obviously, however, it is the function of the doctor to decide whether the patient is sufficiently ill to be in the probable danger of death. The proper way of handling this matter, therefore, is for the doctor to talk over the case with the chaplain, or pastor. The doctor gives the medical information, and the priest makes the decision about the best time for the anointing. This conference between the doctor and priest may also bring to light any psychological problems, such as unfounded fears of the patient or relatives, and will help towards adopting a method of acting that will eliminate these problems.

In the previous paragraph I have taken for granted that there is time for a conference between the priest and the doctor, because the questioner seemed to have in mind such a case. In cases in which a patient becomes suddenly critical, a priest could easily make the decision— and sometimes might have to do so — even before the arrival of the doctor.

9. I have heard that the Holy See raised a moral objection to the making of corneal transplants. Is that true?

It is not true. The foundation for this rumor was a confusing newspaper report concerning a statement made by an unnamed theologian in an unofficial newspaper that happens, I believe, to be printed in Vatican City.

Moreover, even the answer given by the unnamed theologian did not concern corneal transplants as these are ordinarily made. Corneal transplants are ordinarily made either from the eyes of a deceased person or from an eye which had to be removed because of a diseased condition that did not affect the cornea. No theologian would object to either of these methods.

The problem discussed by the theologian in the little newspaper entitled *L'Osservatore della Domenica* had to do with the transplanting of a cornea from a person with two sound eyes to a person who is blind. The Holy See has never made any statement about this case, though some theologians think that the direct sacrifice of a sound eye for the sake of another person is contrary to the papal teaching on mutilation. That was the opinion expressed by the theologian in *L'Osservatore della Domenica.* Many prominent theologians would not agree with this solution. There is an account of this controversy over organic transplantation in *Medico-Moral Problems,* III, 22-25, and a more up-to-date discussion in *Theological Studies,* Sept., 1955, pp. 391-96.

WE REGRET TO REPORT THAT FATHER KELLY IS AGAIN CONFINED TO THE HOSPITAL BECAUSE OF A RECURRENCE OF HIS HEART CONDITION. WE KNOW HIS MANY FRIENDS WILL WANT TO JOIN THEIR PRAYERS WITH OURS FOR HIS WELFARE AND EARLY RECOVERY.

THIRTY YEARS OF A HOLY EXPERIMENT . . .

Bishop Fulton J. Sheen called Mother Anna Dengel, M.D., foundress of the Medical Mission Sisters "one of the truly great women of the world." Speaking before an audience of more than 2,000, the American national director of the Society for the Propagation of the Faith spoke on medicine in relation to the missions. The Bishop traced briefly the history of medical mission work from the time of Saint Luke until the present. He pointed out that it was possible to prove that Saint Luke was a physician just from the Greek words he used in the writing of the Gospel. The dignity and value of the human body was also stressed. Bishop Sheen praised the medical apostolate of which Mother Dengel is the pioneer. The noted speaker said that "Mother Dengel has done more for the missions than any woman alive."

The National Federation of Catholic Physicians' Guilds of the United States presented Mother Dengel with a citation on the occasion of the commemoration of the 30th anniversary of the founding of her congregation.

The citation was presented to Mother Dengel by Monsignor Philip E. Donahue, delegate of Archbishop John O'Hara of Philadelphia. It was the first time in the history of the National Federation of Catholic Physicians' Guilds that the organization presented such an award. The citation appears on the following page.

Mother Anna Dengel thanked the assembled audience for coming to the event since she said "it demonstrates that you are interested in how the other half of the world lives." She expressed the desire that she and the Medical Mission Sisters might live up to the ideal suggested by Bishop Sheen and the citation. Mother Dengel also thanked the Physicians' Guilds, her compatriots as she called them, for accepting her into their midst and for the recognition given to medical mission activities.

The Medical Mission Sisters are an international congregation devoted to the care of the sick in the missions. Sisters who are professionally trained staff hospitals and clinics in India, Pakistan, Africa, Indonesia and North and South America. General headquarters for the congregation are in Philadelphia, Pennsylvania.

Dr. Joseph Toland, immediate past president of the National Federation of Catholic Physicians' Guilds, is president of Men of the Medical Missions which group sponsored the anniversary celebration.

1925-1955

Thirty Glorious Years

Whereas

Mother Anna Dengel, M.D.

had the dauntless courage to pioneer in an uncultivated area of the Lord's vineyard, and

Whereas, her zeal bore fruit in the founding of the

Society of Catholic Medical Missionaries

the first order of its kind in the Church's history, and

Whereas, Mother Dengel's work is internationally and rightfully recognized as a modern spiritual medical crusade, and

Whereas, this incredible accomplishment would be only a pious dream but for the profound faith and love that gave spiritual substance to the extraordinary natural talents of Mother Dengel and her unerring sense of values both human and divine.

Be it resolved that

The National Federation of Catholic Physicians' Guilds of the United States

salutes with prayerful pride a professional equal and a spiritual superior:

May **Mother Dengel and her Sisters of the Medical Missions** *continue their magnificent work of the past thirty years under the guidance and protection of* **God and His Blessed Mother.**

Rt. Rev. Msgr. D. A. McGowan
Moderator

Melvin D. Yahr, M.D.
President

Salute to a Lady

LINACRE QUARTERLY receives many interesting letters from readers and the mail brought one the other day we would like to share with you because it touches off a note that, coming from the heart, expresses one viewpoint we have not included in these pages before. We are grateful to Mrs. Ward for her kindness in writing to us. Here is her letter —

"I am sending a copy of 'A Physician's Wife's Prayer' with the hope that, sometime, you might find a place for it in your publication. (Incidentally, your **Linacre Quarterly** is read avidly by many medics' wives.)

"A Physician's Wife's Prayer"

'Dear God, please grant me a full awareness of my responsibilities as a helpmate to my physician-husband. Help me to cultivate, practice and love the virtue of unselfishness, that he may see in me the perfect wife and helpmate.

'Teach me to sacrifice my own plans cheerfully when they are inconsistent with his duties to the sick and afflicted, and, lastly, sustain me in my effort to shoulder those responsibilities which are mine to bear, that he may be free to minister to those people entrusted to his care. Amen.'

"The prayer is original, having been written by me on the occasion of an invitation by the Norfolk South District Auxiliary to the Massachusetts Medical Sociey to offer an invocation before a luncheon meeting in May.

"Having been the organizer and the first president of this group from 1950-51, and subsequently the president on the State level of the Auxiliary to the Massachusetts Medical Society, 1953-54, I have always tried to further Catholic thought and action by embodying its principles in my talks whenever possible. With so many splendid women representing all faiths in our membership, my experience has been that the woman who is interested enough in her husband's profession to join the Auxiliary, possesses the virtues of faith, hope and charity to a marked degree whether she be a Jewess, Protestant or Catholic...

Frances E. Ward
Quincy, Mass."

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